

# TRANSFORMATIVE MEDIATION IN HEALTHCARE ORGANIZATIONS: A RESOURCE

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## INTRODUCTION

In recent years, conflicts between patients (or their families) and healthcare professionals are more and more frequent. Continuous scientific progress in medicine has created new expectancies in the healthcare system users. Therefore, when their expectancies with respect to the outcome of their health condition are not met, patients (or their families), might suspect that healthcare professionals have done something wrong... (e.g. a worsened condition, which is possible in the evolution of a specific disease, even if the disease is correctly treated, might be perceived as the result of a medical error). Another frequent situation in which users tend to complain is when they have an insufficient or inappropriate communication and/or interaction with the healthcare professionals. This is no surprise, since for most users, the quality of their communication and interaction with healthcare professionals is among the main determinants of the perceived quality of medical care. [1] Inevitably, conflicts are also frequent when an effective adverse event occurs (e.g. unintentional damage to health, morbidity, temporary or permanent disability or patient's death, caused by inadequate performance or lack of medical care). [2, 3]. These are typical situations leading to patients' (and/or their families') loss of trust in a specific healthcare organization or in the whole healthcare system. Beside the negative impact of conflicts on their image, doctors or healthcare organizations might be asked to pay for damages (e.g. monetary compensation requests). It is another important consequence that conflicts with patients might have on the healthcare organizations.

Conflicts are destructive. Initial frustration is expressed through non verbal signals and other specific attitudes and behaviours. If the parties recognize these manifestations, problems can be discussed, clarified and resolved. If they do not recognize them, increasing tension results in verbal expression of emotions and dispute. If parties are open and communicate effectively, problems still can be discussed, clarified

## Introduction

*In recent years, conflicts between patients (or their family) and healthcare professionals and monetary compensations requested for an effective or presumed adverse event are continuously increasing. Conflicts are destructive, as both disputants are suffering: the doctor for the accusations he/she perceives as "unjust", the patient (or their relatives) for the "harm" he/she attributes to low performance of the healthcare organization. Besides, they stop any communication with each other. The transformative mediation approach allows parties to meet and express those values, points of view and feelings which nourish their conflict, without any involvement of the judicial authority. This paper aims to describe the transformative mediation approach and to illustrate its potential in healthcare organizations, through selected case studies.*

## Methods

*Transformative mediation is based on empowerment (parties are enabled to define their own issues and to seek solutions on their own) and mutual recognition (each party listens to and understands the other party's point of view). The steps for the mediation process are: the individual meetings with the parties, the mediation meeting, and the follow-up post-mediation. During the individual and mediation meetings, mediators act as a "mirror" for the parties' feelings (affective dimension of the conflict) and do not assess medical or technical details of the conflict (rational dimension of the conflict).*

## Case studies

*Three conflicting situations between patient's family and professionals from different healthcare organizations in northern Italy, in which a transformative mediation approach was proposed, are illustrated and analysed.*

## Conclusions

*Successful mediation allows healthcare organizations build-up citizens' trust and to preserve their good reputation and may reduce costs, when a damage request is expressed. Neutrality is a big challenge for mediators. Besides, there is always a lot of uncertainty in transformative mediation, as mediators have to cope with human subjectivity. Unfortunately, a number of disputants do not accept mediation, because they fear or dislike confrontation.*

*Keywords: healthcare organizations, conflict, empowerment, mutual recognition, transformative mediation*

and resolved. If they are not open, tension increases and communication between parties becomes more and more difficult. Conflict might be expanded and it is likely to involve more persons or institutions which express solidarity with one or the other of the parties. Besides, conflict now may involve other problems. A polarization of parties occurs, and each one focuses on his/her own purposes, remaining indifferent to the interests of the other party. Parties can try again to solve the conflict, but if they do not succeed, any communication stops and they can not talk to each other any more. In this phase, a third person (e.g. judge, arbiter, negotiator, conciliator) can intervene trying to make peace [4].

An interesting resource that healthcare organizations can use to cope with conflicts between patients and healthcare professionals is transformative mediation. This is an

opportunity for both parties to meet and express those values, points of view and feelings which nourish their conflict, without any involvement of a judicial authority. [5] Mediators do not establish who is wrong or who is right, like judges or arbiters. Mediators let the disputants explain the problem which make them suffer so much, with the aim of facilitating an exchange and clarification. Transformative mediation fosters the parties' empowerment and recognition. Thus, parties are enabled to define their own issues and to seek solutions on their own (empowerment), and to see and understand the other person's point of view (recognition). Empowerment and recognition often pave the way for a mutually agreeable settlement. [6]

This article aims to describe the transformative mediation approach and to illustrate its potential in healthcare organizations, through selected case studies.

## METHODS

### *Selection of cases for mediation*

Conflicts between patients (or their family) and doctors with an important emotional involvement of one or both parties, should be selected for transformative mediation independently whether an adverse event occurred or not (and/or a claim for damage was expressed or not). The conflict protagonists may have addressed first the public relations office, and/or the legal affairs office of the healthcare organization, and/or mass-media. Sometimes disputants spontaneously address the mediation service.

### *Preliminary conditions*

Preliminary hearings and mediation should be organised in a room sufficiently large and lightened, so that environment makes participants feel comfortable. It is preferable to be a room which is not located near the psychology unit, otherwise disputants might misunderstand the mediation purpose.

Mediator can be whoever had a specific training in using the transformative mediation approach, no matter her/his profession. As a general rule in a healthcare organization, mediators should not be wearing white coats during the meetings with the conflict protagonists.

### *Structure of the mediation process*

#### *a) Preliminary meeting with each party (individual meeting)*

After introducing themselves, the mediation team comprising two members should explain the aim of the meeting to the disputants. They inform that the meeting will last between 60-90 minutes and that everything said will remain strictly confidential. Mediators seat down on the same side of the table, having the disputant(s) on the other side.

Usually, one to three individual meetings with each party are organized. The number of the meetings depends on the intensity of the sufferance experienced by each disputant and on his/her willingness to talk about it with the

mediation team. In these meetings, mediators listen carefully to the story, with the aim of identifying what exactly the disputant experienced when he/she was involved in those facts and how strong were his/her feelings. Therefore, from time to time, the disputant is asked by mediators how he/she felt when some particular fact occurred. In alternative, mediators can name a particular feeling they perceived in the disputant when speaking about something that happened and ask him/her whether it was true. Thus mediators act as a "mirror", reflecting the feelings experienced by the protagonist of a conflict (reflection technique). They also try to assess if he/she has the real need to speak to the other conflict protagonist.

#### *b) Common meeting with both parties (mediation meeting)*

A mediation meeting is organized only when individual meetings revealed that both disputants agree to meet each other in the presence of the mediation team. Thus, when this condition is not met, the process stops after the individual meetings.

Mediation team should be now composed of three members: M1, M2 and M3, of whom M1 and M2 have met one of the disputants in the individual meetings and M2 and M3 have met the other one. Thus, only one of them has met both disputants during the individual meetings (M2), while each one of the other two has seen only one of the conflict protagonists.

After the introduction (mediation team members introduce themselves, explain the purpose and the approximate duration of the meeting and underline the confidentiality of the whole process), one of the disputants is invited to tell the facts, while the other is asked to wait for his/her turn without interrupting. During the speech, one of the three mediators summarizes on a paper (which will be destroyed at the end of the meeting), what each disputant said in this first part of the meeting. Then the mediator reads loudly, asking the disputants to tell him/her whether facts were correctly resumed or not. (summary technique)

In the second part of the meeting, disputants are invited to speak about the feelings they experienced during their conflict. They are allowed to interrupt each other if they need so. As in the individual meeting, mediators' task is to accompany disputants in becoming aware of their feelings before, during and after the facts they talked about. They should absolutely avoid trying by all means to make peace. Only acting in this way, can mediators induce a transformation in the disputants. When decisions have to be made, mediators check (i.e. through a question) which are the parties' intentions, but do not make decisions for the latter (check-in technique). While in the individual meeting no one of the disputants knew the feelings of his/her opponent, during the mediation meeting this becomes possible. Thus they can move by themselves (empowerment) from an initial position -in which the other disputant's

feelings were unknown or did not matter for them-, to a new position in which they realize that their opponent has feelings too, and that they are able to understand those feelings. (recognition).

If transformation occurred, mediators formulate the meeting conclusions and thank the conflict protagonists for participation. They also encourage them to feel free to further address the team if they need so. If transformation did not occur in the first mediation meeting, but mediators' intuition is that it might be achieved, another mediation meeting can be organized, if both parties agree.

*c) Follow-up of the parties post-mediation*

The transformation ("reparation choice") that can occur at the end of the mediation meeting is only the first phase of the change process. To reach the final phase, in which peace can be established, more time is needed in order disputants "take a distance" from the initial conflict. ("Mediators know that time is the greatest mediator" states J. Morineau). [7] Therefore, procedure requires that mediators contact each disputant after two weeks, to further assess the effectiveness of the mediation meeting.

## CASE STUDIES

We present below three case studies, describing real situations which happened in various healthcare organizations in northern Italy and which the mediation team was asked to deal with.

### 1. Case A

An old patient accompanied by his son, Mr A, was admitted in the hospital A because his son insisted that it was the unique solution for him to get better. Here worked Dr A - the only doctor who patient's family trusted in the last years-, who took care of the patient. Several days after, the patient gone into coma status and was transferred in the intensive care unit of a bigger hospital, where he died soon after. Mr A addressed the public relations office (PRO) of the hospital A a letter of complain for his father death occurred a few days after his admission, asking for explanations. He also announced he was thinking of formulating a monetary compensation request.

#### *Individual meeting with Mr A (patient's son)*

*a) First meeting*

Mr A was very sad because he insisted himself in convincing his father to address the hospital. When his father deceased, he realized that he had been completely wrong. Besides, it was himself who has chosen the hospital A, which he thought a good hospital until then. His description of the facts revealed great emotion and pain. He could not accept what happened and asked the hospital (PRO) for explanations. He complained about professionals' coldness and indifference. He was angry because of the use of bed contention means in the short time when his father was left

alone. The "defensive" reply (and not "explicative", as he would expected), saddened and offended him. He felt abandoned by the hospital and betrayed. He was angry with the nurses who were not able to understand that his father complained because his clinical condition worsened. Actually it resulted in the patient's coma and transfer in the intensive care unit of a bigger hospital.

*b) Second meeting*

Mr A stressed that the transfer further nourished his pain. He told about his anxiety when a doctor advised him to stay still there, as if he knew the death was close. His father died shortly after. Mr A told with obvious difficulty how his life changed thereafter: he was constraint to take medicines as a consequence of his prostration status and he had to take care of his mother who came to live in his house. He felt an immense loneliness in a world which he called "deaf and obtuse". (He was divorced and had no child). The caregivers' indifference to his father was extremely painful to him. At the end of the meeting, Mr A said that "he felt more peaceful" and that "he understood what did not work". He was hoping this would give him the force to overcome his mourning.

#### *Individual meeting with Dr A*

*a) First meeting*

Dr A revealed his anger with the hospital A medical management which asked him a letter of clarification and informed him about a possible Mr A's compensation request. In his opinion the hospital had already judged and condemned him irremediably. He complained about the medical management which "first attacked and then abandoned him", as "a priori the professional was always thought guilty". He was offended by Mr A's contestation, both as a professional and as an individual, since the latter accused him of "inhumanity", which meant a very "serious accusation".

*b) Second meeting*

Dr A talked about the sacrifices he made to become a doctor. When he was young he studied day and night and had several jobs to maintain himself. He wanted to tell Mr A all that, to express all the sadness he felt and to give him an opportunity to understand him and retire his "unjustified" accusations.

#### *Transformative mediation meeting*

Mr A spoke about his father's death, controlling his anger, but underling the anxiety for that "inhuman and unjust death".

Dr A told he had known the patient seven years before, when the patient's family, who did not trust other professionals, addressed himself. He took care of him ever since, very patiently. He remembered the difficult moments which himself and the patient's son (Mr A) experienced, because the patient was reluctant and it was hard

to convince him to follow any treatment. Dr A was the only professional they trusted (e.g. if the patient was appointed for a check-up at a date and/or an hour when Dr A was not working, he gave-up the check-up rather than address another doctor). Therefore Dr A considered “both false and tragic” Mr A’s accusations and compensation request.

Mr A acknowledged that Dr A was telling the truth. Nonetheless he complained that, after the patient’s transfer in another hospital, Dr A never asked about his condition. He added, with bitterness and anger, that Dr A did not spontaneously provide him with information in that occasion. The trust he had put in Dr A weakened and was completely lost when, after addressing the PRO for explanations, he received an aggressive and defensive reply.

Dr A acknowledged that he had not the necessary force to contact Mr A after his father’s transfer. Mr A acknowledged that Dr A had always facilitated his father’s pathways of care, and that he checked-up his clinical status even without a formal appointment. This was the main reason why he has felt abandoned in the hospital where his father had been transferred. Dr A apologized and expressed his sincere compassion for the death of Mr A’s father. He revealed his sympathy for elderly, as he has been orphan since childhood and has been brought up by his grandfather.

#### ***Follow-up post-mediation***

The post-mediation interpellation by the team revealed that Mr A and Dr A met again in the hospital and spoke face to face.

Mr A said he was not angry anymore with Dr A, because the latter had told him that “even doctors might be wrong”. He felt the doctor was sincere, and noticed that he was suffering, too. He had not surmounted the mourning, but he attributed it to the conflicting relationship he had with his father.

Dr A was grateful to the mediation team for the opportunity he had to meet Mr A after the patient’s death: in this way, Mr A understood that Dr A was the same as before and not a “cynical monster under a mask of good manners”. Dr A told that his colleagues let him alone in coping with this misadventure. He added that, although doctors are extremely vulnerable, just like him, they are unable to share sufferance with somebody else.

## **2. Case B**

Mr B first addressed the mediation service because he needed to be listened to in a difficult moment of his life: his mother, who was admitted in the long-term care department of the hospital B, had just gone into coma status. The following meetings revealed that the patient died shortly after and that Mr B, who suspected that something was wrong with the care given to his mother in that hospital, was thinking about a monetary compensation request.

### ***Individual meetings with Mr B (patient’s son)***

#### ***a) First meeting***

Mr B was deeply suffering because his mother was in coma in the hospital B. He was afraid of losing her and of having no possibility to tell her some important things: mostly how grateful he was to her. Besides, he was offended by the manner in which his mother was treated, being repeatedly transferred from one hospital to another and by the motivations formulated by doctors. He was suffering for his mother’s coma condition, and for realizing that her death was imminent. He remembered his mother ever present, available, welcoming, highly reliable for all the family, and modest. She lived with her husband near the sons’ houses. Mr B spoke about the whole family disorientation, pain and anxiety especially when they went to see her in the long-term care department of the hospital.

#### ***b) Second meeting***

Mr B spoke about his hope to see one day his mother coming to her senses from coma. If he knew that she was suffering because of being in that condition, he would rather prefer she immediately die.

#### ***c) Third meeting***

Mr B said that his mother deceased. He confessed that he felt “empty and guilty” for not having addressed other hospital the night she died. In his opinion, the emergency room (ER) staff of the hospital B noticed that his mother’s condition worsened that night, but did not transfer her in another hospital. He believed that it could have saved her life. He explained that he came to talk about it with the mediation team because he and his family deemed that “it was the right thing to do in the memory of his mother” and because he did not want other people to experience similar events. He expressed pain and anger for his mother’s “absurd death”. His indignation and anger were rather towards the complex healthcare situation than towards Dr B1, who took care of his mother in the hospital B. He just wanted to ascertain whether the transfer from the ER of the hospital B to another hospital could have a positive influence to his mother’s health status. In this way, “staff would become aware of the patients’ right of being considered as a person and not as a number”... He said he did not want a monetary compensation, because nothing could relieve the family’s pain and sufferance.

### ***Individual meetings with Doctors B1 and B2***

#### ***a) First meeting with Doctor B1***

Dr B1, who directly treated the patient, remembered her very well. He also remembered the frustration he felt for not being able to change the course of the events, when she died. He said he felt anger, impotence and sadness not only when he was treating her but also in that very moment, when he was talking about that case.

#### ***b) First meeting with Doctor B2***

Dr B2, the director of the department, wanted to accompany Dr B1 in the first meeting with the mediation

team, but the latter preferred individual meetings with each one. Dr B2 focused more on his personal story: he was divorcing after 26 years of marriage and was overwhelmed by this divorce and his consequences. However he said that he believed it was important to express his sorrow to the patient's family and to assume all the responsibility for what happened.

*c) Second meeting*

Both Dr B1 and Dr B2 decided to directly contact Mr B to apologize and explain him what exactly happened. They said they would not try to convince Mr B to renounce to his claim, if he would eventually formulate a monetary compensation request. They also spontaneously committed themselves to share with colleagues their positive impression about the mediation service and to advise them to address the mediation team when involved in similar situations. "Under the white coat there is a human being", concluded Dr B2.

**Transformative mediation meeting**

According to the doctors' preference (they wanted to directly speak to Mr B, without the mediation team), no mediation was performed by the mediation team.

**Follow-up**

Dr B2 told that Dr B1 and himself spoke to Mr B, who initially was very hostile and aggressive, and in his opinion determined in formulating a monetary compensation request. He thought that Mr B understood their sincerity in apologizing, although he lost trust in hospital B and its staff. He told that Mr B was a "good sense person". Dr B2 explained again his personal crisis, concluding that his divorce had a marked impact on his professional activity. He said he felt guilty for that.

Mr B showed ambivalent feelings toward the two professionals he met. He was aware that they were human beings too, sensitive and suffering, but unfortunately they were unable to listen to him more than one minute without interrupting. He stated that he would insist in obtaining a monetary compensation which he would donate to a voluntary association which supported migrated people. At the end of the meeting, Mr B asked to meet Dr B2 in the presence of the mediation team.

When invited by the team to a mediation meeting with Mr B, Dr B2 replied that he was not able to accept it, as he had just participated in a mediation with his wife (who was divorcing him), and was exhausted. He said he would further call Mr B in a more appropriate moment.

**3. Case C**

Mrs C reported that her husband was not prescribed Heparin (anticoagulant drug), when he was dismissed from the hospital, the day after a surgical intervention for inguinal hernia. When she explicitly asked the doctor if he "should

not make abdominal injections to her husband, since he was a patient at risk, with Parkinson disease and left leg thrombophlebitis usually treated with Coumadine", she was given a negative answer. Fifteen days thereafter, the patient was readmitted in the hospital at the emergency room with fever and right leg tumefaction. A profound thrombophlebitis was diagnosed. The prescribed treatment consisted of Coumadine and elastic support bandage. Mrs C informed the hospital C that she will request a monetary compensation, because "before the surgery her husband had one diseased leg only and, after the surgery, he had two diseased legs". Thus, she wanted "the healthcare system to pay for the negligence and superficiality shown in treating human beings".

**Individual meetings with Mrs C (patient's wife)**

*a) First meeting*

Mrs C appreciated the meeting with the mediation team, although she was explained that its purpose was not to ascertain the technical aspects of her husband's treatment appropriateness.

Mrs C expressed her contrariety and doubts about her husband's medication. She showed worry about the future and distress for her husband's health status. She was angry for what happened and she believed that a medical error occurred. She was exhausted for nursing his husband and was disappointed at not having been listened to by the doctor.

*b) Second meeting*

Mrs C gave more details about the feelings she had expressed during the first meeting. She added that she would be happy with meeting the doctor, although she was aware that it would only be an occasion to give vent to her anger, since she could not be neutral about facts. Mediation team explained her that mediation objective is not necessarily making peace, but giving room to the parties to openly express their feelings about particular circumstances they experienced.

**Individual meetings with Dr C**

*a) First meeting*

Dr C said he was very angry: he had illustrated to the patient's wife the treatment and how to administer it to the patient at home, as he always does. He said he had explained to Mrs C, who asked him about the anticoagulant therapy, that it was not necessary and that- according to the medical protocol- patient's mobilisation would have been enough. He had not seen Mrs C ever since and he had been informed about what happened by the hospital management which asked him to write a letter of response to Mrs C's accusations. Dr C said he was sceptical about mediation which he believed was a tool to reduce the number of citizens' compensation requests. Nonetheless, he confessed that he was wondering why, after the incident reporting, the mediation team was meeting him. He expected the team would meet other professionals arbitrarily

was done wrong. The mediation team explained him that actually it was Mrs C who directly contacted the mediation service. Dr C added that he was angry with Mrs C because he is generally available to patients and he adopts their very language to be sure of their understanding of what he has to communicate to them. Besides, he listens to them, although the time for doing so is always scarce. He complained about the amount of forms doctors have to compile, as these “administrative tasks” shorten the amount of time doctors could spend with patients.

#### *b) Second meeting*

Dr C talked about his tiredness and lack of motivation and about the heavy situation he was experiencing. He liked to be a doctor, but he said he could not stand patients’ family who, like Mrs C, do not listen to him or forget what he explained, accusing him thereafter of negligence and inhumanity. He remembered he had a kind of “sympathy” for Mrs C’s husband and this was one more reason for him to deem her behaviour unjust and offensive. He stressed that, in his opinion, it was not the patient who complained but the wife who was angry with his husband. He concluded that it was painful for him, Dr C, “to be named the scapegoat for all life injustices occurring in this family”.

#### **Transformative mediation meeting**

Mrs C understood that Dr C was deeply sorry for what happened and believed that, had she asked directly Dr C for explanations, she would have received them. Dr C apologized for not having realized that Mrs C was disoriented, stressed and exhausted and she was not able, under those circumstances, to understand and remember the medication information he provided her. Both acknowledged they were betrayed by their misunderstanding. Dr C felt himself guilty for having betrayed Mrs C’s trust, and Mrs C understood that she betrayed Dr C since, being blinded with her anger, she preferred complaining in a very accusatory letter, rather than openly talk with him. Besides, Dr C felt betrayed also by the hospital management, who insisted that he should reply that letter, “abandoning” him. Mrs C explained that her anger was growing because, having noticed the general availability of Dr C for his patients, she was disappointed to see him in such a hurry and acting so superficially. Dr C acknowledged that it was possible he aroused this impression in that occasion, because of excessive stress or tiredness. He suspected that the real cause of their conflict was that he had not understood the dramatic situation the woman was in and left without giving her enough reflection time after delivering her information on medication. No one alluded to the technical aspects of the incident.

#### **Follow-up post-mediation**

During the post-mediation meetings with each one, both Mrs C and Dr C expressed their satisfaction for the mediation. Dr C disclosed that the mediation had a pedagogical effect on him, although participating in the meetings

was rather painful. Mrs C, who was still worried about her husband’s condition, said she felt a little bit less alone. She also confessed to be angry with her husband because he was ill.

## **D**ISCUSSION

In the three examples, patients’ relatives were initially angry and disappointed by the healthcare professionals, as they believed that patients were damaged by the weak performance of the healthcare professionals. They felt betrayed, as they expected their loved ones to leave the hospital being better. They felt the healthcare organization had done them an injustice and wanted it to pay for it. It is important to notice that, while in cases A and B, patient’s condition worsened as a result of a complication of the disease, in case C, an effective adverse event occurred. Nonetheless, it is not task of mediation team to analyse technical inconsistencies in diagnostic and therapeutic procedures. On the other hand, professionals felt angry, offended and betrayed. They felt betrayed twice: first by the patients’ relatives (who seemed to have removed from their minds all the doctors’ commitment in treating patients) and second by their colleagues and the management of the healthcare organization (who seemed to let doctors alone in coping with accusations they received).

In the proposed examples, all disputants revealed to be afflicted by an immense sufferance.

Conflict results in sufferance because it isolates people. Separation hurts as it means loneliness. Mankind is not conceived to live alone and communication with the others is indispensable. Besides, conflict is a rupture between a well known and accepted order and another situation that replaces that order which does not exist anymore or is not anymore recognized, leading thus to the chaos. Mediation allowed the parties to establish a dialogue first with themselves and to build a different vision of their individual situation.

Mediation re-activated the communication channels between parties and helped each of them to find again the lost relation with the other and with him/herself [7].

Through empowerment and recognition, mediators accompanied parties in moving from a blocked phase of their conflict, in which they did not even talk to each other, to a positively evolving phase.

In case A, empowerment enabled patient’s son to define his real problems: he suffered enormously because Dr A, who used to be always present “abandoned” the patient immediately after his transfer to another hospital; the relationship with his father was rather conflicting; he was worried about his own health condition and he had to take care of his mother. He acknowledged that Dr A was suffering for having lost that patient; that he was very sensitive to the senior patients’ condition as he saw in them his own

grand-father who had brought him up; he recognized his humanity and sincerity. Dr A was enabled to admit his main problem: that he had not the necessary force to contact Mr A after his father's transfer. He understood that this attitude of him was painful for Mr A. Another issue Dr A stressed was that hospital management and his own colleagues let him alone to deal with the accusations he received. Thanks to the mediation, disputants in case A changed their initial positions: Mr A was not angry anymore, and Dr A was happy for re-establishing the communication with Mr A. Parties reached this convenient solution for both by themselves, mediators just accompanied them in doing so.

In case B, an effective mediation could not be realized (the mediation meeting can not be imposed to the parties). However, important achievements were possible, during the preliminary meetings with the parties. Mr B was empowered to realize that a crucial issue for him was that his mother had gone sooner than he expected. Dr B1 realized that he was frustrated, because he could not do more for Mr B's mother. Dr B2 realized that his divorce influenced his professional activity. Mr B recognized doctors' humanity and sincerity. Dr B2 recognized that Mr B had to be presented excuses for the sufferance provoked by his experience with that hospital. In this case too, parties were accompanied in finding their own solutions to their conflict, and the mediation team did not seek to find solutions for them.

In case C, mediation enabled Mrs C to define her main problems: she had not been listened to by Dr C, when asking the anticoagulant treatment for her husband and she was exhausted for nursing her husband. She was angry with her husband for being so ill... Mrs C recognized Dr C as an honest person, and that he had always been available to the needs of her husband. Dr C's main problem was that, because of a number of administrative tasks, he had not enough time to pay detailed attention to communication with his patients/their relatives. Other concerns were that his practice might be analysed by a technical commission, and that a priori everyone thought him guilty. He recognized Mrs C was in a dramatic situation and that she needed more attention than he paid to her in his hurry. He recognized her sufferance for what happened and apologized.

In all cases healthcare professionals apologized with patient's relatives. Actually apologizing is a capital element in mediation. In criminology, this is important for the victim, but also for the author of the harm. This is the reparation necessary to overcome the suffering. This is a liberation process both for the victim (who sees the author recognizing his/her facts) and for the author (whose shame and "guiltiness" - of which he/she was not aware until then- are attenuated). [7] In healthcare, most patients who had been victim of a damage indicated that what they wanted was to be presented excuses and given explanations (34% of patients versus 23% who wanted an inquiry on the causes, 17% who wanted help to manage the conse-

quences, 11% who desired a monetary compensation and 6% who asked to be taken disciplinary measures against the author of the damage) [8].

#### *Advantages of transformative mediation*

Transformative mediation has several potential benefits.

First, patients and/or their families and professionals who are in a conflict situation, often generated by an adverse event (that really or just apparently occurred), are given the possibility to be listened to by a team whose focus is the person and not the technical or medical aspects. While the parallel procedure to ascertain the adverse event is going on, the integration with the mediation service allows the healthcare organization to deal with the emotional side of the facts. Mediation is a resource: citizens become aware that the healthcare organization cares about the betrayal and the abandon they experienced within the healthcare system; and doctors understand that they are not let alone in coping with a critical situation they are involved in.

Second, transformative mediation has the potential of reducing judicial proceedings and damage claims. This is true especially when monetary compensation requests waiting to be solved by the judicial authority do not rely on an effective adverse event damaging the patient's condition. Actually a great number of these cases are the result of misunderstanding of diagnostic and therapeutic procedures and/or communication failures in the relationship doctor-patient which generates a conflict. During mediation meetings, it is possible that citizens spontaneously change their attitude toward the damage request: they might renounce to formulate it (if they intended to formulate a request) or retire it (if they already formulated the request). Besides, bringing an action against somebody requires time and money, which transformative mediation can save.

Third, when an effective adverse event occurred, mediation can be the preliminary step for negotiation of the amount of money requested for the damage done. Mediation has the potential of reducing the intensity of negative feelings (e.g. hostility, suspicion, revenge) in which results conflict escalation and which usually impede parties to reach a satisfactory agreement for both of them. (such agreement is typical for negotiation).

Fourth, mediation is an effective help for staff dealing with clinical risk management [2] or public relations in healthcare organizations. Actually, once created, the mediation service relieves this staff of a part of their workload in coping with unsatisfied, angry or deluded users.

Finally, mediation is a resource that helps the healthcare organization to build-up citizens' trust, to preserve its good reputation and to not damage its image [9].

#### *Criticisms to transformative mediation*

Neutrality is one of the biggest challenges for

mediators: they must be empathetic but without being favourable or contrary to the emotions experienced by disputants. Therefore, in the moment when one of the mediators feels this temptation/risk in an individual or mediation meeting, he/she must not speak for a while. In these critical moments, the word should absolutely pass to the other mediator, until the risk disappears. (e.g. this is the main reason why individual and mediation meetings require more than one mediator).[10] Other threats to mediators' neutrality is the temptation to provide necessary professional legal or therapeutic advice or the temptation to give solutions or to direct the process toward more fair solutions.[11] Such critics argue that, at best, mediation should be guided by more formal procedures and structures, in order to protect the disputants from being subject to the mediators' preferences and prejudices [12].

Another criticism refers to the uncertainty about the results of the mediators' work. Although mediator is required to know the conflict and its dynamic, both from a theoretical and practical point of view, as far as he/she deals with human subjectivity, the result of mediation is difficult to be foreseen. But which profession is not subject to uncertainty? Medicine, despite relying on a continuous scientific progress, is not at all as precise as most individuals might be thinking [10,13].

Further criticisms highlight the possibility of harming the parties if an agreement is not reached because of the information disclosed or the emotionality that the process caused (or the agreement in itself does not solve the parties' problems). Besides, there is the possibility that parties use mediation to gain information, win time, or intimidate the other party [11].

Finally one should keep in mind that mediation cannot be imposed, and a number of disputants do not accept mediation meeting because they fear or dislike confrontation.

#### Final remarks

In conclusion, effective mediation is obtained when mediators focus on the details of the ongoing conflict interaction, seeking opportunities for fostering empowerment and recognition. [12] Transformative mediation does not seek to establish who is right and who is wrong (like judiciary system or arbitrate), nor seek to find a satisfactory solution for both parties (like negotiation). Actually mediators should avoid directing the course of the interaction between parties toward settlement. [12] Transformative mediation helps disputants to come out from a blockage or impasse situation, thus preventing/reducing the destructive consequences of conflict. Mediators are not psychological or technical advisors. Mediators only facilitate communication between disputants, in the hope that spontaneous conciliation will become possible, when the seeds of empowerment and recognition, patiently and modestly seeded in the conflict interaction, will grow-up. Feed-back from disputants participating in transformative mediation process recently introduced in northern Italy is very encouraging. Patients (or their family), who were initially angry not only with the doctor but also with the whole

healthcare organization, by which they felt "betrayed", have consequently declared that they were surprised and grateful for having been listened to in individual or mediation meetings. They were satisfied with the fact that the healthcare organization invested in such a tool which builds-up the "human" dimension of the healthcare users and a lost relationship. On the other hand, doctors, who initially were angry and disappointed because they were offended by patients' accusations, consequently appreciated the opportunity they were given to express their own opinions and feelings [9].

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#### References

1. ELEFANTI, M., BRUSONI, M., MALLARINI, E.-*La qualità nella Sanità*. Milano. Egea, 2001,
2. TEREANU, C.-*Managementul riscului clinic: concepte, instrumente, experiențe internaționale (I)*. Medicina Moderna 2007 XIV(6): 327-33, 2007,
3. ANGHELUȚĂ, C.-*Adverse events dangerous but preventable*. Management in Health 2010. 14 (4): 23-9, 2010,
4. POPA, D., ULIANOVSKI, X., DILION, M., ROTARU, V., KOVAL, R.-*Manual de mediere. Chișinău*. Institutul de Reforme Penale, 2006,
5. GADDI, D., MAROZZI, F., QUATTROCOLO, A.-*Voci di danno inascoltate: mediazione dei conflitti e responsabilità professionale medica*. Rivista italiana di Medicina legale 2003, XXV (2-5): 839-56, 2003,
6. BUSH, R., FOLGER, J.P.-*The Promise of Mediation: Responding to Conflict Through Empowerment and Recognition*. San Francisco. Jossey-Bass Publishers, 1994,
7. MORINEAU, J.-*Lo spirito della mediazione*. Milano: Franco Angeli, 2000,
8. McKNIGHT, H.-*Being Open & Honest Policy Policy on Openness and Honesty Following Patient Safety Incidents* March 2008. Available from: <http://www.bolton.nhs.uk/Library/policies/RM008.pdf>, 2008,
9. QUATTROCOLO, A.-*Mediare i conflitti nella relazione medici-paziente*. Quaderni di mediazione. Punto di Fuga Editore 1(3), 2006,
10. QUATTROCOLO, A.-*La mediazione trasformativa: un modo d'intendere e di praticare la mediazione dei conflitti*. Quaderni di mediazione. Punto di Fuga Editore: 29-37, 2005,
11. BUSH, R.-*The Dilemmas of Mediation Practice: A Study of Ethical Dilemmas and Policy Implications. A report on a Study for The National Institute For Dispute Resolution*, NIDR, 1992,
12. FOLGER, J., BUSH, R.-*Ideology, Orientation to Conflict, and Mediation Discourse*. In: Folge, J. and Jones, T. editors. New Directions in Mediation. California: Thousand Oaks, Sage Publications, p. 3-25, 1994,
13. RADU, P.C., TEREANU, C., BACULEA, S.-*Managing Clinical Risk in Romania*. Iranian Journal of Public Health, 37(4): 32-41, 2008.